BENEFIT STATEMENT CHANGE FORM

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Complete this form *ONLY* if you are requesting a change

Please read the following instructions CAREFULLY to make change(s). Place an "X" in the box for each change that applies. Do **NOT** return your benefit statement or the State Board of Retirement Beneficiary Selection/Change of Beneficiary Form to the GIC.

NOTE: Failure to notify the GIC of a new dependent can result in non-payment of the child's medical claims. If you are legally separated or divorced, make sure that your former spouse's relationship code on your benefit statement is listed as "F" (former spouse) not "S" (spouse). If your former spouse is listed as "S" (spouse) you must report that divorce as instructed under #7 below. If you fail to report a divorce or remarriage for you or your former spouse, your health plan and/or the GIC have the right to retroactively seek health claims paid or premiums owed for your former spouse back to the date of remarriage.

NOTE: If your dependent age 19 to 26 is not listed as a full-time student and attends school outside of your health plan's service area, you must update that status by completing and returning the Dependent Age 19 to 26 Enrollment and Change Form; available on our website: **www.mass.gov/gic/forms**.

Please include the items listed after **"MUST SEND"**, if applicable. If these items are not included, your request cannot be processed. Be sure to complete and sign in the box below and return to:

Group Insurance Commission, P.O. Box 8747,
Boston, MA 02114
1.617.727.2310 • www.mass.gov/gic

PLEASE PRINT AND FILL OUT COMPLETELY.

Name of Insured: _____ **GIC ID #** *(Social Security #)*: _____

Street Address: _____ **Telephone #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Signature of Insured: _____ **Date:** _____

1. ☐ I request a birth date correction for: **MUST SEND:** *Copy of corresponding birth certificate(s).*
☐ Self ☐ Spouse ☐ Dependent(s)

2. ☐ My dependent age 19 to 26 is listed on the benefit statement as a full-time student and he or she is no longer a full-time student. Please change my dependent's status to dependent age 19 to 26.
Dependent's address (if different than the insured's address):
Street Address: _____ City: _____ State: _____ Zip: _____

3. ☐ Please remove my dependent age 19 to 26 from my health insurance plan.
Dependent's name: _____

4. ☐ Please change my address to that listed above. I understand that I must also update my address with the post office so that the address change will remain permanent.

5. ☐ The spelling of my spouse's or dependent's name is incorrect. Please correct the spelling of my spouse's/dependent's name from: _____ to: _____

6. ☐ I wish to add to my family health insurance plan:
☐ Spouse **MUST SEND:** *Copy of certified marriage certificate.*
SS#: _____ Spouse's Date of Birth: _____
☐ Dependent(s) **MUST SEND:** *Copy of dependent's birth certificate.*
NOTE: The birth certificate must link either you or your spouse to the dependent.
SS#: _____ Dependent's Date of Birth: _____

7. ☐ I wish to change my marital status from "married" to "legally separated" or "divorced".
MUST SEND: *Copy of the following sections of the legal separation or divorce decree: absolute date, health insurance language, and signature pages.*
My legally separate or former spouse's current or last known home address is:
Street Address: _____ City: _____ State: _____ Zip: _____

8. ☐ I was divorced and remarried on date: _____ **MUST SEND:** *Copy of certified marriage certificate.*

9. ☐ My former spouse remarried on date: _____
Former Spouse's Street Address: _____ City: _____ State: _____ Zip: _____